Association of Health Care Journalists

IMPROVING PUBLIC UNDERSTANDING OF HEALTH AND HEALTH CARE

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

ROLLING HILLS HOSPITAL, LLC	1000 ROLLING HILLS LANE ADA, OK	May 10, 2017

VIOLATION: *QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT* — **Tag No:** A0308

Based on record review and interview, data regarding patient deaths was not being reported to the Governing Body for oversight.

Findings:

A document titled "Patient Deaths 2016" showed 26 deaths for 2016. There was no documentation to show this information was provided to the Governing Body.

During an interview with Staff A on 05/10/17 at 11:21 am, Staff A acknowledged the deaths were not reported to the Governing Body for oversight.

VIOLATION: *NURSING SERVICES* — **Tag No:** A0385

Based on record review and interview the hospital failed to:

A. Ensure nursing qualifications were sufficient to meet the needs of the patients. (See Tag A-0392)

B. Ensure the Registered Nurse assessed and evaluated the care provided to each patient. (See Tag A-0395)

C. Ensure nursing staff develops and maintains a current nursing care plan for each patient. (See Tag A-0396)

VIOLATION: *STAFFING AND DELIVERY OF CARE* — **Tag No:** A0392

Based on record review and interview, the hospital failed to ensure qualifications of the nursing personnel were sufficient to

meet the needs of the patients.

Findings:

A document titled "Phylosophy [sic] of Nursing Care/Definition of Nursing Care" showed Nursing Services consists of a properly trained and competent staff; staff development program includes ongoing orientation, in-service training, continuing education opportunities, etc.

A document titled "Nursing Care Plan" showed delivery of nursing care as purposeful and perpetual application of diversified talents. Nurses shall anticipate difficulties following hospitalization and intervene ...to promote continued progression toward optimal health ...nursing care needs of patients identified using nursing process ...registered nurses (RNs) use assessment skills on an on-going basis to determine interventions and identified needs are addressed ...nursing care is provided by a team with specialized training to meet the needs of the population(s) being served ...will have documented competence and orientation specific to care of patient population being served.

On 5/10/17 at 1:15 pm, Staff B stated the hospital currently has no staff orientation or competencies for common medical conditions identification and early recognition of deterioration.

VIOLATION: *RN SUPERVISION OF NURSING CARE*	**Tag No:** A0395

Based on record review and interview the hospital failed to:

A. Ensure the registered nurse (RN) is accountable for and evaluated the nursing care of each patient.

B. Follow its policy regarding RN assessment/evaluation of patient care every shift.

C. Follow its policy and practice standards regarding an RN completion of admission assessments.

The failed practices had the likelihood for twelve (Patient #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13) of 20 patients to have a delay in recognition of changes in the patient's condition by the RN synthesizing patient data to determine rationale for patient care needs.

Findings:

A document titled "Fall Reduction" showed an RN is required to complete a patient fall risk assessment upon admission.

A document titled "Nursing Assessments/Reassessments" showed Admission Nursing Assessment licensed practical nurses (LPNs) may assist in gathering information, RNs only may complete the assessment ... RNs document assessments each shift.

A document titled "Assessment and Reassessment Protocol" showed all patients assessed every shift by the RN assigned to their care ...assessment documented on Nursing Reassessment form and/or progress note ...any change in physical or mental status requires a reassessment.

A document titled "Nursing Department: Daily Nursing Reassessment Progress Note" showed no evidence of a comprehensive medical assessment including musculoskeletal, cardiovascular, and neurological system. The medical assessment only included vital signs, appetite, bladder, ambulation, skin, breath sounds, and hydration/nutritional assessment.

On 05/10/17 at 12:46 pm, Staff A and Staff B stated reassessment was completed by the nursing staff in the progress notes section of "Daily Nursing Reassessment Progress Note". The assessment should be done daily either days or evenings. Usually the nurse on days completes the assessment. Staff A and Staff B were aware the assessment form only allows for an assessment to be documented daily. The expectation was for nursing staff to complete an assessment each shift. Staff A and Staff B stated they were aware the hospital policy requires nursing assessment by RN each shift.

On 05/10/17 at 1:02 pm, Staff B stated the RN was responsible for completing Section II Integrated Assessment and Fall Risk Assessment. A co-signature was required by the RN when an LPN completes the Integrated Assessment, Fall Risk Assessment and shift assessments. The assessments were required within eight hours of patient admission.

Five (Patients #8, 9, 10, 11, and 12) of 20 medical records did not contain an RN admission assessment, fall risk assessment, or co-signature when LPN completing assessments.

Twelve (Patients #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13) of 20 medical records did not contain an assessment completed for each shift per hospital policy.

VIOLATION: *NURSING CARE PLAN*

Tag No: A0396

Based on record review and interview, the hospital failed to:

A. Ensure nursing staff utilized the nursing process and assessed the patient's medical and psychological condition to determine progress toward goals

B. Ensure the nursing care plan was kept current through ongoing assessment of patient's medical condition and response to interventions

C. Ensure care plan was evaluated and modified to determine progress towards achievement of goals and effectiveness of the care plan

These failed practices had the likelihood to result in delayed recognition and/or treatment of active problems that could influence patient recovery, functional status and quality of life.

Findings:

A document titled "Standards of Nursing Practice" showed the nurse participated in development of a multidisciplinary treatment plan with goals, interventions and nursing actions unique to each patient's needs ...implements nursing actions to promote, maintain or restore physical and mental health, prevent illness and effect rehabilitation.

Academy of Medical-Surgical Nurses Scope and Standards of Medical-Surgical Nursing Practice states...the medical-surgical nurse from assessment data formulates nursing diagnoses, identifies interventions to improve patient's psychological and

physical status, develops and prioritize goals, determines the plan of care and evaluates the outcomes.

Twelve (Patients #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 13) of 20 medical records showed:

A. Nursing staff primary intervention was education of patients with diagnosis of Alzheimer's, dementia and other cognitive disorders for their medical conditions

B. Medical providers were responsible for assessment interventions and only rounded every two to three days.

C. No evidence care plan was updated, evaluated and/or modified to determine the patient's progress towards goal based on nursing assessment

On 05/10/17 at 1:12 pm, Staff B stated the care plans came from the corporate office. No place on the care plan documents the education completed for the patient.